Health Services and Development Agency
State Health Planning and Advisory Board

May 2004

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John G. Morgan
Comptroller

May 5, 2004

The Honorable John S. Wilder
Speaker of the Senate
The Honorable Jimmy Naifeh
Speaker of the House of Representatives
The Honorable Thelma M. Harper, Chair
Senate Committee on Government Operations
The Honorable Mike Kernell, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the performance audit of the Health Services and Development Agency and the State Health Planning and Advisory Board. This audit was conducted pursuant to the requirements of Section 4-29-111, *Tennessee Code Annotated*, the Tennessee Governmental Entity Review Law.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the agency and the board should be continued, restructured, or terminated.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/dlj
04-026

State of Tennessee

Audit Highlights

Comptroller of the Treasury | Division of State Audit

Performance Audit
Health Services and Development Agency
State Health Planning and Advisory Board
May 2004

AUDIT OBJECTIVES

The objectives of the audit were to determine the agency's and the board's legislative mandates and the extent to which they have carried out those mandates efficiently and effectively and to make recommendations that might result in more efficient and effective operation of the agency and the board.

FINDINGS

The State Health Planning and Advisory Board Has Failed to Develop a Comprehensive State Health Plan

At the board's first meeting in January 2003, the board set a goal to complete the health plan in 18 months. However, 16 months after the board first met, it has only just begun to make any progress towards initiating the plan's development. Agency management and board and agency members believe there have been major obstacles to the development of the health plan including the late starting date of the board, difficulties in obtaining the quorum necessary for the board to meet, and a lack of overall focus. Without a current, comprehensive health plan detailing goals, objectives, standards, and criteria, the Health Services and Development Agency is hindered in making its decisions regarding certificates of need. In addition, the lack of a plan limits the ability of executive branch agencies (e.g., the Departments of Health, Mental Health and Developmental Disabilities, and Finance and Administration) to develop a health system that meets the needs of the citizens of the state and improves their quality of life (page 8).

The Quality of CON Decisions May Be Negatively Affected Because the Criteria and Standards Being Used Have Not Been Updated and the Information Provided to Agency Members Is Not Always Current or Verified

The criteria and standards on which certificate of need (CON) decisions are based have not been updated since 2000. In addition, information (self-reported by providers and compiled by the Department of Health) which is used for verifying applicant-provided information is not always verified or up-to-date. Similar issues were identified in prior performance audits. The 1990 audit of the Health Facilities Commission found that (1) the State Health Plan did not contain sufficient statements of goals, objectives, standards, and criteria to adequately guide the commission in its CON decisions; and (2) applicant-provided information was seldom independently verified. The 1994 audit of the Health Facilities Commission and the Health Planning Commission found that the accuracy of applicant-provided information was not ensured and that the State Health Plan lacked strategies for achieving its goals in the broader context of health planning (page 13).

The State Health Planning and Advisory Board Has Numerous Vacancies (Including Representatives of Consumers and the Elderly) Resulting From Resignations or Expired Terms

As of March 2004, there were 11 vacancies (4 empty slots and 7 slots currently filled by members whose terms have expired) on the 34-member State Health Planning and Advisory Board. By law, the board must have a super majority of 22 members to constitute a quorum; therefore, the vacancies hinder the board's ability to conduct business, including the development of the State Health Plan. (See finding 1.) Four of the 11 vacancies are the result of resignations. Two of those positions have been vacant since April 2003; the two others have been vacant since January 2004. The remaining seven vacancies represent board members whose terms expired effective June 30, 2003, but who continue to serve because no reappointments or new appointments have been made for their positions (page 17).

OBSERVATION AND COMMENT

The audit also discusses the adequacy of actions taken to address conflict-of-interest issues that negatively affected the agency's predecessor, the Health Facilities Commission (page 6).

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INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of the Health Services and Development Agency and the State Health Planning and Advisory Board was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Section 4-29-225, the Health Services and Development Agency and the State Health Planning and Advisory Board are scheduled to terminate June 30, 2004. As provided for in Section 4-29-115, however, the agency and board could continue through June 30, 2005, for review by the designated legislative committee. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the agency and board and to report to the Joint Government Operations Committee. The performance audit is intended to aid the committee in determining whether the agency and the board should be continued, restructured, or terminated.

OBJECTIVES OF THE AUDIT

The objectives of the audit were

1. to determine the authority and responsibility mandated to the agency and the board by the General Assembly;

2. to determine the extent to which the agency and the board have fulfilled their legislative mandates and complied with applicable laws and regulations; and

3. to recommend possible alternatives for legislative or administrative action that might result in more efficient and effective operation of the agency and the board.

SCOPE AND METHODOLOGY

The activities and procedures of the Health Services and Development Agency and the State Health Planning and Advisory Board were reviewed for the period August 2003 through January 2004. The audit was conducted in accordance with the standards applicable to performance audits contained in G*overnment Auditing Standards* issued by the Comptroller General of the United States. The methods used included

1. a review of applicable statutes and rules and regulations;

2. examination of the agency's files, documents, meeting minutes, policies, and procedures;

3. review of prior performance and financial and compliance audit reports and audit reports from other states;

4. interviews with agency staff, Department of Health staff, and agency and board members; and

5. interviews with staff of, and review of relevant documents from, similar agencies in other states.

The General Assembly has designated the Comptroller of the Treasury (or his designee) to both serve as a member of the Health Services and Development Agency and to audit the agency.

ORGANIZATION AND RESPONSIBILITIES

The Health Services and Development Agency was created by Section 68-11-1601 et seq., *Tennessee Code Annotated*, effective July 1, 2002. The agency, which is responsible for administering the certificate of need program (see page 4), assumed the duties of the Health Facilities Commission (HFC), which ceased to exist on June 30, 2002. (See page 6 for a discussion of the conflict-of-interest problems that contributed to the HFC's termination and the changes that have been made to deal with such potential problems.)

The Health Services and Development Agency has nine members:

- the Comptroller of the Treasury or his designee;

- the Director of TennCare or his designee;

- the Commissioner of the Department of Commerce and Insurance or her designee;

- one consumer member appointed by the Speaker of the Senate;

- one consumer member appointed by the Speaker of the House of Representatives;

- one person (nominated by the Tennessee Hospital Association) with recent experience as an executive officer of a hospital or hospital system, appointed by the Governor;

- one licensed physician (nominated by the Tennessee Medical Association) appointed by the Governor;

- one representative of the nursing home industry (nominated by the Tennessee Health Care Association) appointed by the Governor; and

- one consumer member appointed by the Governor.

As of March 2004, there were no vacancies. The agency has nine staff, headed by an executive director. (See page 21 for a table of agency staff.)

The State Health Planning and Advisory Board was created by Section 68-11-1625, *Tennessee Code Annotated*. The purpose of the board is to develop a State Health Plan and to review and evaluate the plan at least annually. Furthermore, in developing the State Health Plan, the scope of the board's duties and responsibilities include:

- submitting the plan to the Governor for approval and adoption;

- holding public hearings as needed;

- responding to requests for comment and recommendations for health-care policies and programs;

- conducting an ongoing evaluation of Tennessee's resources for accessibility, including but not limited to financial, geographic, cultural, and quality of care;

- reviewing the health status of Tennesseans as presented annually to the board by the Department of Health and the Department of Mental Health and Developmental Disabilities;

- reviewing and commenting on federal laws and regulations that influence the health-care industry and the health-care needs of Tennesseans;

- involving and coordinating functions with such state entities as necessary to ensure the coordination of state health policies and programs in the state;

- preparing an annual report for the General Assembly and recommending legislation for its consideration and study; and

- establishing a process for timely modification of the State Health Plan in response to changes in technology, reimbursement, and other developments that affect the delivery of health care.

The board is also mandated to review current criteria and standards, and adopt those criteria and standards as guidance for the issuance of certificates of need until such time as a new State Health Plan is developed.

The board is composed of 34 members, 30 of them appointed—24 by the Governor, 3 by the Speaker of the Senate, and 3 by the Speaker of the House of Representatives. In addition, the

Commissioner of the Department of Health; the Commissioner of the Department of Mental Health and Developmental Disabilities; the Chair of the Senate Finance, Ways and Means Committee; and the Chair of the House Finance, Ways and Means Committee serve as ex officio voting members. As of March 2004, there were 11 vacancies as a result of resignations or expired terms. (See finding 3.)

According to statute, the board is to be staffed administratively by the agency "until such time that the agency has developed a planning and data resources staff."

REVENUES AND EXPENDITURES

The Health Services and Development Agency is funded through CON application fees and charges for other miscellaneous CON-related services. Unexpended fees do not revert to the state's general fund but rather are maintained as reserves of the agency. For fiscal year 2003, the agency had revenues of $925,081 and expenditures of $724,257. For fiscal year 2004, the agency has estimated revenues and expenditures of $1,295,400. As of March 8, 2004, the agency had reserves of $559,000. The above revenues and expenditures include revenues and expenditures associated with the activities of the State Health Planning and Advisory Board. (See finding 1 regarding the board's activities thus far.) Fees collected annually from the state's health-care providers are to be used to carry out the board's health planning functions. Nearly $111,000 was collected in fiscal year 2003, and over $114,000 is expected to be collected in fiscal year 2004.

CERTIFICATE OF NEED (CON) APPLICATION PROCESS

Before health-care providers can build facilities, become licensed, or conduct business, they must be granted a certificate of need by the Health Services and Development Agency. In order for a certificate of need to be granted, a provider must establish that the proposed service is needed, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health-care facilities and/or services. Thirty-six states and the District of Columbia have a CON approval process in place, including Tennessee's contiguous states of Alabama, Arkansas, Georgia, Kentucky, Mississippi, Missouri, North Carolina, and Virginia.

Tennessee's current certificate of need process, which is essentially the same process as that used by the Health Facilities Commission, has very specific time frames. The process begins when the provider (i.e., the entity applying for a CON) files a Letter of Intent (LOI) with the agency within the first ten days of the month. During the same ten days, the provider must publish a notice in the local newspaper(s) where the service will be provided. The notice is paid for by the applicant, and its purpose is to notify anyone in the public who may be affected and may want to comment on the application. Agency staff review the LOI to ensure it meets all standards and specifications as set by statute. If the LOI does not meet all standards, it is voided, and the process must begin again.

Within five days of publication of the Letter of Intent, the provider must submit the CON application to the agency. Agency staff review the application to determine whether it is complete and contains the necessary information regarding intent. According to agency management, there are usually questions regarding the application, and staff must contact providers for clarification. Staff then send the applications to the department responsible for regulation of the facility or service (either the Department of Health or the Department of Mental Health and Developmental Disabilities), for the purpose of verification of the data the applicant is using to justify the request for the CON. The vast majority of the applications go to the Department of Health for review and verification. (For example, all applications filed in 2003 went to the Department of Health for review.) The department generally completes these reviews within 60 days. (See finding 2 regarding concerns about the review process.)

After the review is completed, agency staff schedule a public hearing. Generally, hearings occur in the month following completion of the review, and two to three months after the Letter of Intent is first received. The applicant makes a presentation offering justification for the CON, followed by any opposition to the CON application. In addition, the public can request the opportunity to speak either on behalf of, or in opposition to, a proposal.

Approximately two weeks prior to the date of the hearing, staff provide agency members with an application packet that includes the LOI, the application, any supplemental information, and a Department of Health (or Department of Mental Health and Developmental Disabilities) report. When making their decisions, members rely on criteria and standards included in *Tennessee's Health Guidelines for Growth, 2000 Edition*. (See finding 2.) The agency is to consider the following three major criteria in determining whether an application for a CON should be granted:

> Need – The health care needed in the area to be served is evaluated on factors including the relationship of the proposal to any existing applicable plans; the population served by the proposal; existing or certified services or institutions in the area; and the extent to which Medicare, TennCare/Medicaid, and low-income groups will be served by the project.
>
> Economic Factors – The probability that the proposal can be economically accomplished and maintained is evaluated based on factors such as whether adequate funds are available to complete the project; the reasonableness of the proposal's costs; anticipated revenue from the proposed project; and the impact on existing patient charges.
>
> Contribution to the Orderly Development of Adequate and Effective Health-care Facilities and/or Services – This criterion is evaluated based on factors including conformance to the goals for quality health care for Tennesseans contained in the State Health Plan to be outlined by the State Health Planning and Advisory Board; relationship of the proposal to the existing health-care system; and any positive or negative effects attributed to duplication or competition.

During 2003, the agency received 124 applications for certificates of need. Of these, 90 were approved, 10 were denied, 13 were voided or withdrawn, and 11 were pending.

OBSERVATION AND COMMENT

ACTIONS TO ADDRESS CONFLICT-OF-INTEREST ISSUES APPEAR ADEQUATE

Legislation enacted to establish the Health Services and Development Agency (HSDA) appears to have adequately addressed concerns regarding issues of conflicts of interest and ex parte communications associated with the Health Facilities Commission (HFC).

The primary reason for the restructuring of the old commission was to deal with abuses in the certificate of need (CON) process, primarily conflicts of interest on the part of commission members, ex parte communications, and the influence of lobbyists. According to one agency member, the ex parte rules were not clearly defined under the prior statute, and politics played a large role in CON decisions, which led to a loss of confidence in the commission as a governmental agency.

Some HFC members had serious conflict-of-interest problems; for example, some members were making CON decisions where they had a direct conflict of interest. One member continued to sit and rule on CON decisions, even though he had clear conflicts of interest (and was advised by the commission's General Counsel to recuse himself because of those conflicts), until spring 2002. During the 2002 legislative session, the General Assembly passed legislation creating a new agency to replace the HFC and strengthening conflict-of-interest provisions affecting the CON process. The term of the commissioner discussed above expired with the termination of the HFC, and he was not reappointed to the new agency. Only three members from the former commission are members of the current agency: the Governor's consumer appointee, the Speaker of the Senate's consumer member, and the Comptroller of the Treasury's designee.

Because of the problems with the former commission, the legislation written for the new agency contains very strict language with regard to conflicts of interest. Section 68-11-1604(e)(7), *Tennessee Code Annotated*, requires all agency members to "annually review and sign a statement acknowledging the statute, rules and policies concerning conflicts of interest." Furthermore, statute requires that "any member, upon determining that a matter scheduled for consideration by the agency results in a conflict with a direct interest, shall immediately notify the executive director and shall be recused from any deliberation of the matter, from making any recommendation, from testifying concerning the matter, or from voting on the matter. The member shall join the public during the proceedings." Furthermore, "any member with an indirect interest shall publicly acknowledge such interest" and "all members shall make every reasonable effort to avoid even the appearance of a conflict of interest."

Before the new legislation was enacted, applicants would often contact and lobby members prior to the CON hearing. According to agency management, there was no way to know what communications a member had with an applicant prior to an HFC hearing. Under the new legislation, however, members are prohibited from having any contact with applicants prior to meetings. Pursuant to Section 68-11-1607(d)(1), *Tennessee Code Annotated*, "no communications are permitted with the members of the agency once the letter of intent initiating the application process is filed with the agency. Furthermore, any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the executive director and a written summary of such communication shall be made part of the certificate of need file." Under Title 8, Chapter 44, of *Tennessee Code Annotated* (the Open Meetings law), agency members are also prohibited from discussing agency business (such as CON applications) prior to the application hearing, limiting the potential for collusion.

As required by statute, the agency has developed a conflict-of-interest policy that addresses and reinforces the conflict statute. The purpose of the policy is "to assure that the activities of the agency members, employees, and staff do not conflict or have the appearance of conflicting with the unbiased administration of the state's certificate of need program." The policy is applicable to all agency members, executive employees, and staff. All agency members and staff are required to annually update a statement acknowledging they are familiar with the policy. (See below.) State Health Planning and Advisory Board members are not required to sign the form, as statute does not include them, nor are they involved in CON decisions.

Based on an auditor review, the policy appears comprehensive and adequate in addressing concerns related to conflicts of interest. The policy prohibits any agency member from making a recommendation concerning, deliberating, or voting on any project in which that member or an associated institution or business has a direct or conflicting interest, including any project subsequent to consideration of a certificate of need application. The policy is three pages long and also provides examples of situations that may constitute a conflict.

Although all current agency members have signed conflict statements as of 2004, no agency member signed a statement during 2003 as required. Members signed statements in August 2002, upon taking their seat, and did not sign a statement again until February 2004, after auditors asked for documentation of signed statements.

Agency staff have taken steps to ensure agency members are aware of and understand the new policy. At the first meeting in August 2002, the agency's General Counsel summarized the conflict-of-interest policy for agency members, and the Executive Director instructed members to recuse themselves, if necessary, when a project with which they have a conflict is announced. Based on interviews with agency members, they are familiar with the conflict policies and conscious of the policies' importance in the independence of the CON process. Based on interviews with agency members and staff, agency members are abiding by the new conflict requirements, and there have not been any obvious conflict-of-interest problems, such as those that occurred under the Health Facilities Commission.

We reviewed voting records from all agency CON hearings from August 2002 (the agency's first meeting) through January 2004. Our analysis appears to support the agency members' and staff's view that conflict-of-interest issues have been adequately addressed. We did not identify any trend in voting patterns among board members that might indicate potential collusion. In addition, agency members are adhering to the direction and requirement to recuse themselves when necessary. During the 17 meetings held between August 2002 and January 2004 (no meeting was held in July 2003 due to the lack of a quorum), agency members recused themselves from CON decisions 25 times.

FINDINGS AND RECOMMENDATIONS

1. The State Health Planning and Advisory Board has failed to develop a comprehensive State Health Plan

Finding

The State Health Planning and Advisory Board has not developed a State Health Plan as required by statute. At the board's first meeting in January 2003, the board set a goal to complete the health plan in 18 months. However, 16 months after the board first met, it has only just begun to make any progress towards initiating the plan's development. Without a current, comprehensive health plan detailing goals, objectives, standards, and criteria, the Health Services and Development Agency is hindered in making its decisions regarding certificates of need. In addition, the lack of a plan limits the ability of executive branch agencies (e.g., the Departments of Health, Mental Health and Developmental Disabilities, and Finance and Administration) to develop a health system that meets the needs of the citizens of the state and improves their quality of life.

According to Section 68-11-1625, *Tennessee Code Annotated*, the purpose of the board is to develop a State Health Plan that is reviewed and evaluated at least annually. The plan is to guide the state in the development of health-care programs and policies, and the allocation of health-care resources in the state. The board is also mandated to review current criteria and standards, and adopt those criteria and standards as guidance for the issuance of certificates of need until such time as a new State Health Plan is developed. (See finding 2.)

The board chair summarized the board's task as being "to develop a comprehensive health plan to serve as a guide not only for the CON [certificate of need] process but also for others involved in health care, private as well as state. The board is to develop a comprehensive and dynamic health plan that will adjust to changing times. The plan should reflect everyone's interest in the highest quality of care, balanced by what is cost effective."

There have been recurring problems over the years related to the development of a State Health Plan. The March 1990 performance audit of the Health Facilities Commission found that

the 1985-1990 plan did not "contain sufficient statements of goals, objectives, standards, and criteria to adequately guide the [Health Facilities] commission in its decisions on certificates of need." The 1994 audit of the Health Facilities Commission and Health Planning Commission found that the 1990-1995 State Health Plan adopted by the Health Planning Commission lacked strategies for achieving broad goals assuring needed services are developed.

Agency management and board and agency members believe major obstacles to the development of the health plan include the late starting date of the board, difficulties in obtaining the quorum necessary for the board to meet, and a lack of overall focus. The board had a late start in achieving its goal because it was unable to meet until six months after its development. By legislation, the board was created to start on July 1, 2002. However, at that time, many seats had yet to be filled, and the board was unable to meet until January 2003 because there were not enough seats filled to make a quorum.

The board met nine times from January 2003 through January 2004. However, the board was able to obtain a quorum at only three of those meetings. (The board cannot officially meet and do business without a quorum.) Agency management views the quorum problem as consisting of two separate issues. First is the problem with attendance, which management and staff believe they are addressing by communicating with board members and encouraging them to attend. The second, and perhaps more important issue, is the quorum requirement. Section 68-11-1625(a)(7), *Tennessee Code Annotated*, requires that "twenty-two members [out of 34 total] shall constitute a quorum." One board member believes the reason for this large quorum is to limit the ability of a small number of members to take control of decision-making.

Agency management and members believe that either the size of the board should be reduced or the size of the quorum requirement should be reduced, perhaps to a simple majority. According to agency management, if the quorum requirement had been 18 instead of 22 members, the board would have had a quorum every time. Based on a review of attendance records, this is an accurate statement. Management believes it is important to recognize that the board comprises CEOs, physicians, and department commissioners, for example—high-profile and very busy individuals. By the nature of their occupations, these members' attending meetings usually requires clearing a calendar and shifting office staffs. However, board members presumably understood their responsibilities when they accepted a position on the board. Attendance at meetings is clearly expected under the board's legislation, which states that members of the board are subject to removal if they fail to attend at least 75 percent of board meetings in any year.

At one point during the April 2003 board meeting, the chair stated that "a very preliminary" draft of a health plan would be discussed at the May 2003 meeting. However, because of the lack of a quorum, no official board meeting could be held in either May or June 2003. At the July 2003 board meeting, further subcommittee reports on criteria were presented, and the chair stated that a draft of a plan would be presented at the September meeting for review. However, no meeting was held in August, and in September 2003, the board failed to obtain a quorum. (According to agency staff, no plan was developed.)

Based on a review of transcripts from board meetings, no major discussion or initiative towards the development of the plan was made until the October 2003 meeting. While it appears little, if any, progress towards development of the plan had been achieved earlier, this meeting, held ten months after the board first met and was presented with its role, finally produced a statement defining the role of the board: "to establish the direction of the State Health Plan by determining the vision, the mission, and the core values and strategic goals; not the depth but the major strategic goals that will move the plan forward."

The agency, to which the board is administratively attached, received a $500,000 budget increase in fiscal year 2004 for development of the plan. At the October 2003 meeting, the board approved hiring a facilitator at a cost not to exceed $5,000, to provide guidance and direction towards development of the health plan; hiring two health planners, a statistical analyst, and an administrative assistant to help develop the plan; and establishing a time frame for completion of the plan. The facilitator will be paid to facilitate the development of the plan but will not actually write the plan. However, no time frame was set at this meeting, and as of February 2004, no date had been established. Agency management has estimated it could take 18 to 24 months to complete the plan. (In recent months, board members have also discussed hiring contract consultants to write the plan.)

According to agency management, the cost of writing the plan, including the cost of hiring additional staff, will be paid with board funds (currently $110,000-$115,000 in revenue per year) from annual fees paid by licensed health-care providers. Management could not estimate the final cost to develop a plan.

Although no plan has been developed, the board has made some progress in reviewing the standards and criteria used in making CON decisions. At the initial meeting in January 2003, the board approved adoption of *Tennessee's Health Guidelines for Growth*, developed in 2000. These guidelines encompass the criteria and standards to be used by CON applicants and the reviewing authority to generate baseline information during the review process. The information is then used as the basis for decisions concerning CON proposals and as a component of a State Health Plan.

During initial meetings, the board established a task force, which then established several subcommittees to assess and amend current criteria used in the CON decision-making process. The four subcommittees are organized to cover the following health topic areas:

- Long-Term Care—nursing homes, swing beds, comprehensive inpatient rehabilitation, home health, hospice, residential hospice, psychiatric inpatient services, ICF/MR, mental health residential treatment facilities, alcohol/drug abuse residential treatment facilities, and non-residential methadone treatment facilities;

- Acute Care—acute care, burn unit, NICU, discontinuance of OB, birthing centers, long-term care hospital beds, health-care institutions (construction, renovation, expansion, and replacement), and cardiac catheterization and open heart;

- Medical Equipment/Outpatient—medical equipment, ambulatory surgery treatment centers, and outpatient diagnostic centers; and

- Contract Scope/Needs Assessment.

The subcommittees have begun to review current criteria and standards for CONs and made comments at board meetings regarding CON categories. The subcommittees appeared to be making progress, periodically reporting to the board progress in establishing criteria updates.

Recommendation

The State Health Planning and Advisory Board needs to determine priorities and take the necessary actions to ensure the State Health Plan is developed and adopted as soon as practicable, as required by statute. These actions should include identifying the major components the board needs to address in developing a plan, determining the order in which those components should be addressed, and setting time frames for each component. As an extension of this process, the board and the agency need to work together with the relevant executive branch agencies (e.g., the Departments of Health, Mental Health and Developmental Disabilities, and Finance and Administration) to implement a state health planning system that will provide for (1) the ongoing collection of reasonably current, accurate health-related data; and (2) the ongoing review and revision (as needed) of the criteria, standards, and overall State Health Plan. In theory, the results of such a health planning system could be used to direct not only the certificate of need process but also other aspects of the state's health-related activities.

The board and agency should consider whether the size of the board and/or the size of the board's quorum requirement should be reduced. If changes are needed, the agency should propose legislation to the General Assembly.

Management's Comments

Comments from Dr. Ron Franks, Chairman, State Health Planning and Advisory Board

We concur. Because of the stringent requirements related to obtaining a quorum of 2/3 of the membership, the Board did as much as it could. It spent its time gathering background information necessary to develop a health plan, established a priority list of health issues facing the people of the state, and developed an outline of a health plan. The Board further agreed on an action plan to finalize the values and vision to be expressed in the plan, as well as finalize the overall scope of the health plan. A consultant to facilitate the process was identified. No quorum could be reached over a six-month period, resulting in multiple cancellations of meetings necessary to move the process toward completion. Further, as members resigned from the HPAB, there were several attempts to re-populate the committee through the required nomination process, but without success.

Despite these problems, the Board was successful through a series of subcommittees, to review the current CON guidelines and recommend changes to those needing urgent attention. Again, because of the failure of a quorum, the Board was not able to gain final approval of its recommendations to the Health Services and Development Agency for changing the CON guidelines, even though there was a general impression that the Board would have favorably passed the suggested revisions.

Comments from Management of the Health Services and Development Agency

We concur. The statutory scheme for the Health Planning and Advisory Board is set out in T.C.A. §68-11-1625. Health Planning and Advisory Board members and Agency staff have made a determined effort to ensure that the Board fulfills its statutory duties. Two problems have prevented success in that endeavor. First, the Board is too large to function effectively. Secondly, the statute requires a "super quorum" of 22 out of 34 members. Agency staff and the Chair of the Health Planning and Advisory Board repeatedly requested that members of the Board attend its meetings. Agency staff arranged informational sessions to provide the Board with background information needed to develop the state health plan. Representatives from the Departments of Health and Mental Health and Developmental Disabilities, TennCare, Division of Mental Retardation Services, University of Tennessee at Knoxville and Memphis provided information to the Board. Monthly meetings were scheduled in advance and frequent reminders were sent to Board members regarding the meetings. Unfortunately the Board achieved a quorum only three of the nine times the Board met. Ultimately, it became impossible to effectively conduct Board business.

However, subcommittees of the Board have been very successful in updating criteria and standards for the issuance of certificates of need. Agency staff continues to provide staff support for this process. New criteria and standards have been completed or are nearing completion for home health, hospice, residential hospice, acute care, open heart, cardiac catheterization, magnetic resonance imaging and positron emission tomography.

The legislature is addressing the need to remedy the statutory impediments to the drafting of a new state health plan. House Bill 1387 by House Leader McMillan and Senate Bill 555 by Senator Clabough would abolish the Health Planning and Advisory Board and transfer the task of drafting a new state health plan to the Department of Finance and Administration. Agency management has been working closely with the sponsors, industry groups and the Department of Finance and Administration to assure a smooth transition. It appears the bill has broad support. It has passed out of the House Health and Senate General Welfare Committees.

We agree that a new state health plan should be developed and adopted as soon as practicable. However, the State Health Planning and Advisory Board has proven to be unwieldy due to its size and quorum requirements. The Agency recognizes the size of the Board and/or the size of the quorum requirement should be reduced. Agency staff made that recommendation to the Administration before this Legislative session began. Legislation to abolish the Board and shift the responsibility of drafting a new state health plan to the Department of Finance and Administration may render this issue moot (House Bill 1387 by Leader McMillan and Senate Bill 555 by Senator Clabough).

2. The quality of CON decisions may be negatively affected because the criteria and standards being used have not been updated and the information provided to agency members is not always current or verified

Finding

The criteria and standards on which certificate of need (CON) decisions are based have not been updated since 2000. In addition, information (self-reported by providers and compiled by the Department of Health) which is used for verifying applicant-provided information is not always verified or up-to-date. Similar issues were identified in prior performance audits. The 1990 audit of the Health Facilities Commission found that (1) the State Health Plan did not contain sufficient statements of goals, objectives, standards, and criteria to adequately guide the commission in its CON decisions; and (2) applicant-provided information was seldom independently verified. The 1994 audit of the Health Facilities Commission and the Health Planning Commission found that the accuracy of applicant-provided information was not ensured and that the State Health Plan lacked strategies for achieving its goals in the broader context of health planning.

Tennessee's CON program is administered by the Health Services and Development Agency pursuant to Section 68-11-1601 et seq., *Tennessee Code Annotated*. (See page 4 for a description of the CON process.) According to Section 68-11-1605, the agency has the responsibility to review applications for certificates of need for health-care institutions, services, and facilities, and to grant or deny applications based on their merits within the context of the local, regional, and state health needs and plans. The Departments of Health and Mental Health and Developmental Disabilities provide technical support for the agency in the form of written reviews and analyses of proposed projects comparing criteria and standards developed by the board with the applicant's projections and the existing data in the service area.

Lack of Updated Criteria and Standards

In 2000, the Health Planning Commission prepared an update of the CON criteria and standards and added some areas that previously did not have standards, including hospice care, methadone clinics, and birthing centers. According to agency management, however, the updates to standards were more or less developed without any input from the Health Facilities Commission or the public. In 2002, when the Health Services and Development Agency was created (replacing the Health Facilities Commission), the old criteria and standards were adopted as guidance until the State Health Planning and Advisory Board could develop updated criteria and standards as part of the development of a State Health Plan. (See finding 1.) The development of criteria and standards and the approval of CON applications should be linked to the state's health plan to ensure that certificates of need issued will promote the state's long-term health goals.

The board has the responsibility to develop and update (as needed) the criteria and standards. The board's subcommittees are currently in the process of developing updated criteria (see page 10). Agency members, who make the decisions to deny or grant CON applications based on the criteria and standards, expressed concerns regarding the board's failure thus far to develop

updated criteria and standards. One agency member expressed concerns that the current criteria are not clear and have not been updated to keep up with technology advances (e.g., MRI and PET scans).

Information Not Always Current or Verified

According to Section 68-11-1608, *Tennessee Code Annotated*, the Departments of Health and Mental Health and Disabilities are required to review each application whose subject matter is within their respective jurisdiction according to the process described in the rules of the agency. The reviewing department (most often the Department of Health) has no more than 60 days to prepare a written summary report of the CON application. At a minimum, these reports are to provide verification of applicant-submitted information; documentation or a source for the data; reviews of applicant participation or nonparticipation in TennCare; analysis of the impact of proposed projects on the utilization of existing providers and the financial consequences to existing providers from any loss of utilization from the proposed project; and specific determinations about the consistency of a proposed project with the State Health Plan.

In conducting its review, the Department of Health's Health Statistics Division makes use of several documents but primarily uses *Tennessee's Health: Guidelines for Growth, 2000 Edition* and the Joint Annual Report. The *Guidelines for Growth*, prepared by the former Health Planning Commission and in use until the State Health Plan is completed, includes the basic criteria and standards for health care in Tennessee, and specifies facility utilization standards—for example, inpatient bed days per 1000 targets for hospitals. (As noted above, this document has not been updated since 2000.) The Joint Annual Report is an annual self-reporting document for hospitals, home health agencies, and nursing homes, for example. Other sources of information used by Health Statistics as references include licensure survey reports, certified beds in licensure facilities, Tennessee population projections, Bureau of TennCare reports, hospital discharge data, and other ancillary information including newspaper/television reports and state legislative action.

Agency staff and members expressed concerns regarding the lack of up-to-date information from the Department of Health and the department's ability to verify, with some degree of accuracy, applicant data projections. Hospitals and other health-care providers self-report the information, and the Department of Health does not generally verify the accuracy or the completeness of the reported information. In addition, the data are outdated. Providers submit data to the department annually and have a deadline of April to submit data from the prior year. Thus, the information may be over a year old when it is submitted. The data is then reviewed, and the time to conduct this review further diminishes the timeliness of the data before the agency has access. According to agency members and staff, the information used to make CON decisions is often at least two years or more old. Because of concerns about the data, agency management has considered hiring additional staff to assist in collecting data to be used in making CON decisions or contracting out for such data-gathering services.

Based on our review of meeting transcripts and attendance at hearings, agency members sometimes raise questions during CON hearings regarding the reliability or adequacy of the criteria and data used in making CON decisions. For example, questions were raised regarding the lack of adequate criteria or guidelines for some health categories, the absence of charge data

that the Department of Health collects from hospitals, and the reliability of the information in the Joint Annual Report. According to one agency member, the primary reason members ask so many questions at hearings is because of concerns about the quality of data. Often agency members have no other data to rely upon, which raises concerns about the quality of the CON decisions reached.

Recommendation

The agency should work with the Departments of Health and Mental Health and Developmental Disabilities and take additional immediate actions as needed to ensure that information on which certificate of need decisions are based is both accurate and current. In addition, the agency should work with the State Health Planning and Advisory Board to ensure that the revisions to the criteria are completed as soon as possible and that the criteria are reviewed continuously and upgraded as needed, as required by statute.

Management's Comment

Comments from Management of the Health Services and Development Agency

We concur in part. The Health Planning and Advisory Board only assumed responsibility for the criteria and standards in 2002. They were adopted, as required by statute, at the Board's first meeting. Since then, subcommittees of the Board have worked diligently and effectively to rewrite portions of the criteria and standards.

We concur that the information provided by the Department of Health as part of its independently and statutorily required responsibilities is not current. Agency members have expressed concern regarding the age of the data. The primary source of data currently used by the Department of Health in certificate of need reviews is the Joint Annual Report. This document is filed annually by most health care providers. This is a self-reporting hard copy survey. Agency management and Department of Health managers have met and will continue to meet to try to improve the data issues. Agency management recognizes that the Department has lacked the financial and personnel resources needed to improve the data system. Agency management believes that once the Department of Health is able to accept electronic data submissions from all health care providers the data will be more current. Agency management would suggest that the Department of Health consider using claims data from health providers to help improve the review and verification process. Claims data would be more accurate and timelier since it is being reported to payors.

It is our understanding that the hospital claims data collected by the Department of Health, Hospital Discharge Data System (HDDS) is limited to inpatients and ambulatory surgery patients of hospitals. It is also our understanding that it has only been within the last few months that 2001 data has been deemed final data. Any data more recent than 2001 is still being labeled as provisional data. Our review of several other states indicates that claims databases are the main sources of data. Some of those states have hospital patient data which include detailed

patient data but also have ambulatory data which include detailed patient level data from licensed short-term acute care hospitals, licensed ambulatory surgery centers, freestanding radiation therapy centers, lithotripsy centers, and cardiac catheterization labs. Additionally, these other states make their data publicly available within six months' time on a quarterly basis; i.e., data for full calendar year 2003 is now available.

Most providers of health care have some type of claims database. Vendors with proprietary databases develop models providing detailed forecasts for outpatient diagnostic centers, physician offices, home health agencies & hospice as well. The potential for comprehensive timely databases for the large majority of services and facilities that are subject to the CON process is available. Agency management has scheduled a meeting with the Department of Health to review these suggestions.

Legislation is pending that will require the Department of Health to provide more current data (House Bill 3134 by Armstrong, Senate Bill 2596 by Ford).

While we concur in part that the quality of CON decisions may be affected by the data, it should be noted that Agency members collectively bring broad and significant expertise regarding various aspects of the health care field, health planning and business to their review of applications; and Agency staff provide a thorough review of applications before they are "deemed complete" and submitted for the Agency's consideration. Updated criteria and standards and an improved data collection process would certainly improve a certificate of need program that has resulted in no Agency decisions being overturned on appeal and has enjoyed broad support in the health care industry.

The Agency will continue to work with the Departments of Health and Mental Health and Developmental Disabilities to improve the review process. However, the statutory responsibility for data verification lies with the reviewing agency. The Agency has no statutory authority to mandate changes in how these agencies collect data. Agency staff will continue to provide a thorough review of Certificate of Need applications through the "deeming complete" process. The Agency has provided strong staff support for the Board's subcommittee(s') work on the CON criteria and standards. Agency management is committed to continue working on that process if requested by the Department of Finance and Administration should the proposed legislation (shifting responsibility of drafting a new state health plan to that department) is passed.

3. The State Health Planning and Advisory Board has numerous vacancies (including representatives of consumers and the elderly) resulting from resignations or expired terms

Finding

As of March 2004, there were 11 vacancies (4 empty slots and 7 slots currently filled by members whose terms have expired) on the 34-member State Health Planning and Advisory Board. By law, the board must have a super majority of 22 members to constitute a quorum; therefore, the vacancies hinder the board's ability to conduct business, including the development of the State Health Plan. (See finding 1.) Four of the 11 vacancies are the result of resignations. Two of those positions have been vacant since April 2003; the two others have been vacant since January 2004. The remaining seven vacancies represent board members whose terms expired effective June 30, 2003, but who continue to serve because no reappointments or new appointments have been made for their positions. Because the board's legislation does not address what happens in such cases, the agency has taken the position that board members whose terms have expired may continue to serve until new appointments or reappointments are made. However, members with expired terms may be less likely to continue attending, further contributing to the board's inability to achieve a quorum.

Section 68-11-1625, *Tennessee Code Annotated*, which establishes the board, defines the appointment makeup of the board. The board is to be composed of 34 members:

- 4 ex officio voting members (the commissioners of the Departments of Health and Mental Health and Developmental Disabilities, and the chairs of the Finance, Ways and Means committees of the Senate and House of Representatives);

- 24 members appointed by the Governor, representing various health-care concerns in the state and recommended by organizations including the Tennessee Medical Association, the Tennessee Hospital Association, the Tennessee Health Care Association, and the Tennessee Association of Home Care, as well as by organizations representing various business interests, local governments, and the elderly; and

- 6 consumer members appointed by the Speakers of the Senate and House of Representatives (3 each) who are knowledgeable of health needs and services and representative of the consumers of health care in Tennessee, but are not direct providers of health care goods or services.

Of the four seats currently vacant because of resignations, three are consumer seats to be appointed by the Speaker of the Senate, and one is the Governor-appointed seat representing organizations for the population over the age of 65. These vacancies significantly reduce representation of consumers and the elderly on the board. Overall, 8 of the 11 vacant seats are Governor-appointed seats, and the other three are Speaker of the Senate appointments.

The agency is responsible for notifying the Governor and the Speakers of the Senate and House of Representatives whenever a vacancy occurs. According to agency management, agency staff have been aggressive in ensuring that expired seats are filled, by notifying the Governor's office and contacting nominating associations that make recommendations. One problem noted by management is the large, diverse nature of the planning board. Some of the associations named to recommend board members do not have prepared lists of potential nominees. As a result, obtaining a recommendation may take a substantial amount of time.

Recommendation

The agency should continue efforts to notify the administration and legislative officials responsible for nominating applicants to unfilled or expired board seats. Also, the agency should improve efforts to notify professional agencies and encourage prompt recommendations for potential applicants. The agency should consider seeking clarification from the Attorney General's Office regarding allowing board members to participate in board actions after their terms have expired.

Management's Comment

Comments from Management of the Health Services and Development Agency

We concur. Agency staff had frequent discussions with the Governor's and Speaker of the Senate's offices regarding appointments. We believe at some point in early 2004 legislative leadership, industry leadership and the Governor's office determined that the legislative scheme for health planning should be reworked, to include abolishing the Health Planning and Advisory Board. Agency staff has worked with interested parties on the transition. It follows that no appointments would be made to a Board that is to be abolished. The vacancies did not significantly affect the Board's ability to execute a health plan, because four members with expired terms have continued to serve key roles in the Board's health planning process at the subcommittee level. Whereas the members of the Health Services and Development Agency are specifically prohibited from serving beyond their appointed terms by statute (TCA §68-11-1604(c) (1)), there is no express statutory prohibition regarding members of the Health Planning and Advisory Board. The relevant statutory language (TCA §68-11-1625 [a][5]) states that "[m]embers of the board shall be subject to removal by the governor or the speakers accordingly for neglect of duty or failure to attend at least seventy-five percent (75%) of the meetings of the board in any years . . . vacancies shall be filled by the governor or speakers as appropriate."

The Agency will continue to notify the Administration and Legislative Officials responsible for the appointment process when terms are near expiration. Although not required to do so by statute, Agency management contacted professional organizations regarding submitting nominations to the Administration and Legislative Officials and will continue to do so. If the Board is not abolished by the above-mentioned legislation, the Agency will seek clarification from the Attorney General's Office as to whether Board members may participate in Board actions after their terms have expired.

RECOMMENDATIONS

ADMINISTRATIVE

The Health Services and Development Agency and the State Health Planning and Advisory Board should address the following areas to improve the efficiency and effectiveness of their operations.

1. The State Health Planning and Advisory Board needs to determine priorities and take the necessary actions to ensure the State Health Plan is developed and adopted as soon as practicable, as required by statute. These actions should include identifying the major components the board needs to address in developing a plan, determining the order in which those components should be addressed, and setting time frames for each component. As an extension of this process, the board and the agency need to work together with the relevant executive branch agencies (e.g., the Departments of Health, Mental Health and Developmental Disabilities, and Finance and Administration) to implement a state health planning system that will provide for (1) the ongoing collection of reasonably current, accurate health-related data; and (2) the ongoing review and revision (as needed) of the criteria, standards, and overall State Health Plan. In theory, the results of such a health planning system could be used to direct not only the certificate of need process but also other aspects of the state's health-related activities.

2. The board and agency should consider whether the size of the board and/or the size of the board's quorum requirement should be reduced. If changes are needed, the agency should propose legislation to the General Assembly.

3. The agency should work with the Departments of Health and Mental Health and Developmental Disabilities and take additional immediate actions as needed to ensure that information on which certificate of need decisions are based is both accurate and current. In addition, the agency should work with the State Health Planning and Advisory Board to ensure that the revisions to the criteria are completed as soon as possible and that the criteria are reviewed continuously and upgraded as needed, as required by statute.

4. The agency should continue efforts to notify the administration and legislative officials responsible for nominating applicants to unfilled or expired board seats. Also, the agency should improve efforts to notify professional agencies and encourage prompt recommendations for potential applicants. The agency should consider seeking clarification from the Attorney General's Office regarding allowing board members to participate in board actions after their terms have expired.

Appendix
Health Services and Development Agency
State Health Planning and Advisory Board
Title VI Information

All programs or activities receiving federal financial assistance are prohibited by Title VI of the Civil Rights Act of 1964 from discriminating against participants or clients on the basis of race, color, or national origin. In response to a request from members of the Government Operations Committee, we compiled information concerning federal financial assistance received by the Health Services and Development Agency and the State Health Planning and Advisory Board, and the agency's and board's efforts to comply with Title VI requirements. The results of the information gathered are summarized below.

The Health Services and Development Agency does not receive any direct federal financial assistance. However, the agency is responsible for regulating the health-care industry through the certificate of need program and receives fees from health-care institutions applying for certificates of need. Those health-care institutions may be the recipients of federal financial assistance. The State Health Planning and Advisory Board receives license fees from health-care providers that may also be recipients of federal financial assistance.

The agency and the board do not report to any federal agency concerning Title VI and have not prepared a Title VI plan. (The agency has, however, prepared Affirmative Action plans.) According to the agency's General Counsel, neither entity has received any Title VI complaints. If the agency or board did receive a complaint, the General Counsel would handle the complaint process.

The general criteria for the certificate of need (CON) program state that the agency, in determining whether an application for a CON should be granted, considers and evaluates the health care needed in the area to be served. One of the factors in evaluating need is the service area population, including accessibility by consumers, particularly women, racial and ethnic minorities, and low-income groups.

The agency has one contract for FY 2003-2004.

Vendor	Contract Amount	Service Provided	Ownership
Center for Nonprofit Management	$2,700	Facilitator for State Health Planning and Advisory Board	Corporation

See page 21 for a summary of the agency's employees, broken down by gender and ethnicity. (The board currently has no staff.) As of March 2004, the agency had 10 staff, of whom 50% were female and 50% were male. There are no minorities employed by the agency.

Health Services and Development Agency
Staff by Title, Gender, and Ethnicity
As of March 2004

	Gender		Ethnicity					
Title	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Administrative Assistant 1		1					1	
Administrative Services Assistant 2		1					1	
Administrative Services Assistant 3		1					1	
Administrative Secretary		1					1	
Assistant Executive Director	1						1	
Attorney 3	1						1	
Executive Director		1					1	
General Counsel 2	1						1	
Health Planner 3	2						2	
Totals	5	5	0	0	0	0	10	0
Percentage	50%	50%	0%	0%	0%	0%	100%	0%

The agency board has nine members; 67% of the members are male and 33% are female, and 33% are minorities.

Health Services and Development Agency
Board Members by Gender and Ethnicity
As of March 2004

	Gender		Ethnicity					
Title	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Board Member	6	3	0	3	0	0	6	0
Totals	6	3	0	3	0	0	6	0
Percentage	67%	33%	0%	33%	0%	0%	67%	0%

The State Health Planning and Advisory Board has 30 members (7 with terms that expired on June 30, 2003) and 4 vacancies. Of the 30 members, 73% are male, 27% are female, and 23% are minorities.

State Health Planning and Advisory Board
Board Members by Gender and Ethnicity
As of March 2004

	Gender		Ethnicity					
Title	Male	Female	Asian	Black	Hispanic	Indian	White	Other
Board Member	22	8	0	7	0	0	23	0
Totals	22	8	0	7	0	0	23	0
Percentage	73%	27%	0%	23%	0%	0%	77%	0%

Comments from Management of the Health Services and Development Agency

The Agency received a memorandum from John Birdsong, State Title VI Director, on April 15, 2004, which is the same day the Comptroller's Office indicated the Agency might be required to submit a plan. The memorandum requested that all State agencies review Title VI requirements. After discussions with Mr. Birdsong he suggested we seek an opinion from the Governor's counsel and the Attorney General. We are awaiting those responses. If it is determined the Agency should file a Title VI plan, the Agency will give that task high priority.